Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2017	2017_685648_0017	025720-17	Resident Quality Inspection

Licensee/Titulaire de permis

PORANGANEL HOLDINGS LIMITED
2231 MEDHAT DRIVE MISSISSAUGA ON L5B 2E3

Long-Term Care Home/Foyer de soins de longue durée

KING CITY LODGE NURSING HOME
146 Fog Road King City ON L7B 1A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOVAIRIA AWAN (648), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 29, 30, 2017, December 01, 04, 05, and 06, 2017.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), and residents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_268604_0013	116

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure when a resident is being reassessed and the plan of care is reviewed and revised because care set out in the plan has not been effective, different approaches been considered in the revision of the plan of care.

Resident #004 was identified for nutrition risk during the RQI. Review of resident #004's clinical records identified significant changes in weight over identified periods of time. Review of resident #004's progress notes identified the home RD assessed the resident and acknowledged the documented significant weight changes.

Review of resident #004's written plans of care spanning the period reviewed during the course of the inspection, identified resident #004 to have risk factors compounding his/her nutrition risk.

Record review of resident #004's progress note identified he/she was assessed by the physician, and diagnosed with an identified medical condition during the period of the significant weight changes reviewed at the time of this inspection. Resident #004's records identified he/she was assessed by the RD during the identified period. No changes to the nutrition interventions for residents were recommended for resident #004.

Interview with the homes RD identified that he/she would assess residents in the home who have had changes in their health, significant weight changes, and change in their appetite. The RD reported that significant weight changes would warrant an assessment and appropriate interventions would be considered. Resident #004's clinical records, written plan of care, and his/her significant weight changes were reviewed with the RD. The RD reported that he/she had not been made aware of resident #004's acute weight change at the beginning of the period reviewed during the RQI, and would have considered an appropriate nutrition intervention to mitigate the increased nutrition risk to resident #004 due to this significant weight change. The RD further identified that he/she was aware of resident #004's subsequent significant weight change but was unable to demonstrate whether different approaches had been considered in the revision of the resident's' plan of care at the time.

Review of the above staff interviews and resident #004's clinical records with the homes DOC acknowledged that the home failed to ensure that when a resident was being assessed and the plan of care was revised, that different approaches had been

considered to address resident #004's ongoing significant weight changes when initially identified. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a weight change 5 per cent of body weight, or more, over one month, are assessed using an interdisciplinary approach, and any other weight change that compromises the resident's health status.

Resident #004 was identified in stage 1 of the RQI for weight loss.

Review of resident number #004's clinical records identified a significant weight change over an identified period of time. Subsequent monthly weights following the identified weight change confirmed it as a true weight change.

A documented assessment acknowledging or addressing the identified weight change for resident #004 was not identified in the resident's clinical care records reviewed during the inspection.

Interview with PSW #102 identified that resident's in the home would be weighed monthly, and those identified to have sustained a true weight change (following a reweigh to confirm) of more than 2.2kg would be reported to registered staff and subsequently the homes RD would follow up.

Interview with RN #103 identified resident's would be weighed at the beginning of the month within the first week. By the eighth day of the month, the resident's identified to have a true weight change of more than 2.0kg would be immediately referred to the homes RD for assessment. The home’s RD would receive a hard copy referral in the Dietary Communication Book and subsequently address it on his/her next visit to the home. Review of resident #004’s weight trigger for the identified time period with RN #103 identified it as a true weight change. The Dietary Communication Book and resident #004's clinical care records were reviewed with RN #103. RN #103 acknowledged a referral had not been made to the homes RD and resident #004 had not been assessed for his/her significant weight change at the time.

Interview with the homes RD reiterated RN #103’s review of the homes referral pathway to the RD. Resident #004’s significant weight change trigger identified at the time of the inspection was reviewed with the RD. Further review of resident #004’s weight for the following months, with the RD during the interview, acknowledged resident #004 had sustained a true weight change putting the resident at high nutrition risk. The homes’ RD identified that he/she had not received a referral for resident #004 following this significant weight change, and that resident #004 had not been subsequently assessed.

Review of the above staff interviews and resident #004’s clinical records with the homes DOC acknowledged that the home failed to meet the legislative requirement for an interdisciplinary assessment of a resident experiencing a significant weight change of 5 per cent or more of body weight over one month. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that residents with a weight change of 5 per cent of body weight, or more, over one month, are assessed using an interdisciplinary approach and that actions are taken and outcomes evaluated.

Resident #001 was identified in stage 1 of the RQI for weight loss.

Review of resident number #001's clinical records identified he/s had sustained a documented significant weight change over a specific time period.

A documented assessment acknowledging or addressing the weight change for resident #001 for the identified period was not identified in the residents' clinical care records reviewed during the inspection.

Interview with PSW #102 identified that residents' in the home would be weighed monthly, and those identified to have sustained a true weight change (following a reweigh to confirm) of more than 2.2kg would be reported to registered staff and subsequently the homes RD would follow up.

Interview with RN #103 identified residents' would be weighed at the beginning of the month within the first week. By the eighth day of the month, the residents' identified to have a true weight change of more than 2.0kg would be immediately referred to the homes RD for assessment. The home's RD would receive a hard copy referral in the Dietary Communication Book and subsequently address it on his/her next visit to the home. Review of resident #001's weight trigger for the identified period at the time of the inspection, with RN #103 identified it as a true weight change. The Dietary Communication Book and resident #001's clinical care records were reviewed with RN #103. RN #103 acknowledged a referral had not been made to the homes RD and resident #001 had not been assessed for his/her significant weight change at the time.

Interview with the homes RD reiterated RN #103's review of the homes referral pathway to the RD. Resident #001's significant weight loss trigger identified on October 5, 2017, was reviewed with the RD. Further review of resident #001's subsequent weight status, with the RD during the interview, acknowledged resident #001 had sustained a true weight change putting the resident at high nutrition risk. The homes' RD identified that he/she had not received a referral for resident #001 following this significant weight loss, and that resident #001 had not been subsequently assessed for the significant weight change.

Review of the above staff interviews and resident #001's clinical records with the homes DOC acknowledged that the home failed to meet the legislative requirement for an interdisciplinary assessment of a resident experiencing a significant weight change of 5 per cent or more of body weight over one month. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's policy entitled "Medication Incident" (Index I.D.:F-45), revised October 17, 2017, states that all medication incidents are to be reported to the resident (if cognitive), the substitute decision maker, the Director of Nursing, the Medical Director, prescriber and the pharmacy service provider. The physician is to be notified immediately if there appears to be a serious problem, otherwise on the next doctor's visit.

Review of the home's medication errors binder for the period of 2017 indicated that four medication incidents occurred. The medication incidents did not result in harm to any of the resident's.

Upon review of the medication incidents it was discovered that the substitute decision makers (SDMs) of residents #'s 20 and #21 were not notified. An interview held with DOC confirmed that the medication incidents involving the identified residents were not reported to the SDM's as required by the homes policy and regulation 135(1). [s. 135. (1)]

Issued on this 31st day of January, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.